

MEDICAL ASSISTANCE OVERVIEW

A-100 PURPOSE AND APPLICABILITY

The Medical Assistance program manual incorporates eligibility policy for all medical assistance programs including family medical groups, children's groups, specialized households, Nevada Check Up and Medical Assistance to Aged, Blind and Disabled (MAABD) groups.

Exceptions to medical assistance policies are noted in each chapter; otherwise the policy is applicable to all programs.

A-105 MEDICAL ASSISTANCE OVERVIEW

The Affordable Care Act (ACA) requires all individuals to maintain minimal essential health coverage beginning January 1, 2014. Individuals who do not maintain minimal essential health coverage (MEHC) may face tax penalties for noncompliance. (MEHC) includes Medicaid, Medicare, government-sponsored programs, employer-sponsored health plans, and private insurance plans offered through a state's health insurance exchange.

Certain individuals may be excluded from the individual responsibility requirement. Individuals with religious objections, individuals not lawfully present in the U.S., and incarcerated individuals are excluded from the individual responsibility requirement. In addition, an exemption from the tax penalty is available for any individual who:

- Has coverage available that is considered cost prohibitive because their required contribution for coverage exceeds 9.5% of the annual household income;
- Has a household income of less than 100% of the Federal Poverty Level (FPL);
- Is a member of an Indian Tribe and eligible for services through an Indian health care provider;
- Has been without minimum essential coverage for less than three months; or
- Has obtained a hardship waiver from HHS because, for example, there is no affordable qualified health plan available to the individual through his or her employer or an exchange.

The ACA allows states to expand Medicaid to cover low-income adults and children with income up to 138% of the FPL. In addition, individuals and families who have income above the Medicaid level but below 400% of the FPL will receive tax credits to help them purchase coverage in the new health insurance exchange. People with income up to 250% of the FPL, receiving premium credits, will also get additional assistance with their cost-sharing charges.

States are required to coordinate eligibility across the different insurance affordability programs. The health reform law establishes new definitions of income – called Modified Adjusted Gross Income (MAGI) that will be used in determining eligibility for advanced premium tax credits (APTC), Family Medical assistance and Nevada Check Up (NCU). Medical Assistance to the Aged, Blind and Disabled (MAABD) groups are exempt from the MAGI budgeting rules.

Individuals applying online will be evaluated for APTC, Medicaid and NCU and the electronic application will be referred to the appropriate agency based on the application information. Individuals determined ineligible due to excess income will be referred to the exchange for an APTC eligibility determination.

Medicaid and NCU eligibility determinations will be made using MAGI budgeting methodology to determine family size and household income. MAABD eligibility determinations will continue using SSI budgeting methodology to determine family size and household income.

A-110 COOPERATION

All applicants and/or their authorized representative are required to furnish information and/or documentation necessary to establish initial and continuing eligibility in order to receive medical assistance. If a caregiver or household fails or refuses to cooperate with the Division of Welfare and Supportive Services (DWSS) district office, quality control, Investigations and Recovery or other designated DWSS officials in providing information which would impact pending or ongoing eligibility/benefits, the case will be denied or terminated.

In a noncooperation situation resulting in termination, allow applicable adverse action and provide legal notification.

A-115 PRIOR MEDICAL (435.915)

Prior medical assistance is available for up to three months prior to the application month. If the individual is requesting the coverage for prior months and received medical services in the month(s) for which Medicaid is requested they must meet all eligibility requirements for that month.

A-115.1 Applying for Prior Medical Coverage

A request for prior medical assistance is considered a separate application because it is for months predating the initial application. Prior medical requests may be added during the pending period and during the 12 month period after approval, provided the case remains open. Approval, denial or pending of a prior medical request must always be addressed in a notice of decision to the household.

Prior medical assistance may be provided even if:

- The household is **not currently** eligible for Medicaid; or
- The person who received the medical care or services is deceased.

Do not delay an ongoing eligibility decision while obtaining information to determine prior medical eligibility. In addition, if the household is only requesting prior coverage, provide an ongoing eligibility decision at the time of the application.

If the individual is aged, blind or disabled and an SSI recipient determine if they would have been eligible for SSI had the Social Security Administration made a determination. This category of eligibility is used only after all other eligibility categories have been considered.

Do not make an independent SSI determination if there is a pending SSI application covering the month(s) Medicaid is requested. Use the Social Security Administration's SSI disability decision (the disability onset date) for any month of requested prior medical assistance. All other factors of eligibility, e.g., residency, citizenship, income, resources, etc., must be evaluated by the case manager.

Prior medical determinations must be made within 45 days from the application date for all categories except for disabled applicants which are given 90 days for processing.

Exceptions:

Nevada Check Up (NCU) applicants are eligible beginning the **next administrative** month. Because these decisions are prospective, they are not eligible for prior medical coverage.

Qualified Medicare Beneficiary (QMB) applicants are eligible beginning the month immediately following the month the decision is made. Because these decisions are prospective, they are not eligible for prior medical coverage.

A-115.2 Verification of Prior Medical Assistance

The following are required for approval of prior medical assistance:

- Prior medical assistance must be requested; AND,
- There must be evidence (paper documentation or documented telephone call to the provider) that medical care or services were provided in the month(s) for which medical assistance is requested **Note:** Medicare premiums are acceptable verification of a service; AND,

- Actual income (ie: paper documentation or telephone call to employer) for the prior medical month(s) being requested must be used; AND
- Citizenship documentation must be received prior to approval of prior medical months unless eligibility is being determined under the emergency medical services group.

A-120 AUTHORIZED REPRESENTATIVE (A/R)

Clients may designate anyone they choose to act on their behalf by completing the A/R section on the application, using the Authorized Representative Form 2525, **OR** they may sign a "Release of Information" allowing the Division to release case information to individuals or agencies/organizations.

The A/R must be:

- An adult, 18 years of age or older.
- Designated in writing. This designation must include the name and address of the person chosen as an A/R, the signature of the household member making the choice, and the date.

If the designation is made by a household member who is unable to or cannot sign, their mark must be witnessed by someone other than the A/R.

With each subsequent reapplication, a new request, Form 2525 and/or Release of Information is required. It is not necessary at redetermination, unless the client indicates a change of A/R.

Power of Attorney status varies with each client. Obtain a completed Form 2525 designating the Power of Attorney as either primary or secondary representative.

There are two types of A/R's:

1. **Primary** - A primary representative receives all requests for information along with any attachments plus all notices. They hold the same responsibility as the client in securing information for determining eligibility, reporting responsibilities and they are the only one authorized to sign on behalf of the client. Primary representatives also have the same access to case information as a client. Legal guardians are always considered primary representatives. **There will be only one primary representative.**

Note: If an applicant lists an individual on the application as an A/R, they will automatically be entered as a primary representative. It will be the responsibility of the A/R to notify the division that they no longer wish to be listed as an authorized representative for the applicant.

2. **Secondary** – A secondary representative receives all requests for information and notices. They are not held responsible for securing or reporting information; however, if they choose, they may secure and report information to the division. Secondary representatives also have the same access to case information as a client.

Note: If an applicant lists an organization or facility, on the application, as an A/R, they will automatically be entered as a secondary representative.

Exception: Department of Health and Human Services (DHHS) divisions administering home and community based waiver programs are automatically entered as secondary authorized representatives to ensure they receive all notifications and are able to assist clients in completing necessary paperwork. Form 2525 is not required for DHHS divisions.

When applicants are unable to designate an A/R AND there are no family members or the existing family members do not wish to assist the applicant, the hospital, nursing home or county agency social service staff may designate themselves as an A/R.

The hospital, nursing home or county agency must make good faith efforts to contact family members of the applicant for information to help determine eligibility. The hospital, nursing home or county agency must provide the names and addresses of family members they contacted or tried to contact.

The case manager will send Form 2534 to the relatives advising them of the application, the hospital, nursing home or county agency representative and request any eligibility information to assist in processing the case.

Note: Division employees may serve as an A/R for a Medicaid case.

A-120.1 Spousal Authorization

A spouse whose income and resources are countable in determining a client's financial eligibility, and is not applying for or receiving assistance, must sign an Interface Consent, Form 2179-EE, authorizing DWSS to interface with other federal and state agencies for information and verifications.

A-125 MEDICAID CARD ISSUANCE AND RESTRICTED STATUS

All newly approved Medicaid recipients are issued a permanent plastic Medicaid card. When a household reports non-receipt of their Medicaid card, ensure NOMADS information is correct and then refer the client to Customer Service to request a replacement card be sent to the recipient.

A new Medicaid card is automatically issued if the client's name, date of birth or gender are changed and/or updated. A new card is NOT automatically issued when the address is changed.

Households where the use of the Medicaid card is questionable may have their card stamped with a restrictive endorsement.

A-125.1 Issuance of Verification of Medicaid Eligibility Status or Form 2636, Pending Welfare Assistance Notice

Issue a verification of Medicaid eligibility or pending status to the household only if they

- have not received a Notice of Decision or a medical card;
- need eligibility verified to receive medical services; and,
- do not have access to a current Medicaid card.

The household or member will not have a current Medicaid card if

- Medicaid is newly approved and the initial notification has not been received;
- they moved and the card was returned by the post office;
- the card was lost or destroyed; or
- eligible family members are separated from each other.

Verify current eligibility only if the most recent Medicaid eligibility status for the household member is

- open (no close date shown); and,
- reflects regular Medicaid coverage (Eligibility Code 5, A, B or P).

Note: If the case is pending, the Eligibility Code will be 7.

A-130 MANAGED CARE ENROLLMENT

Through the Division of Health Care Financing and Policy (DHCFP), Nevada Medicaid and Nevada Check Up operates both a fee-for-service (FFS) and a managed care reimbursement and service delivery system to provide covered medically necessary services to its eligible populations. Managed care is a method of payment and a care delivery model that allows providers to bill the managed care organization. FFS is a payment model that allows the medical provider or facility to bill the DHCFP's fiscal agent directly.

Managed care enrollment is only available for MAGI based medical groups for recipients in the urban areas of Washoe County and Clark County. Certain medical groups are voluntary enrollment in Managed Care Organization (MCO), such as Native Americans, children with special health care needs enrolled in a Title V program, severely emotionally disturbed (SED) children and adults with severe

mental illness (SMI). The aged, blind and disabled populations are not eligible for managed care, nor are those recipients who are also Medicare eligible or receiving SSI benefits.

Initial enrollment in managed care is processed based on the client's choice at application. Individuals applying online will be given the choice online and the managed care choice should be entered into the MEMB screen when processing paper applications. Households must choose one managed care plan for all eligible household members.

If a household fails to choose a managed care plan the case manager must leave the field blank and DHCFP will randomly assign them to one of the MCO's. All recipients will be allowed the opportunity once a year, during open enrollment, to change MCO's.

When a request is made to change MCO the recipient must write to Hewlett Packard Enterprise Services (HPES) to change their MCO. The request must include:

- their billing number;
- what MCO they want to change to; and
- signature and date of the request.

Requests are mailed to:

HPES
PO Box 30042
Reno, NV 89520

A-135 SERVICES PROVIDED BY NEVADA MEDICAID

The following pamphlets provide information about services available from the Nevada Medicaid Program:

- 3200-SM, Medicaid - Title XIX
- 3395-SM, Healthy Kids
- 3324-SM, Family Planning Services
- 3050-SM, MOMS Brochure
- 3479-SM, Medicaid Enrolled Health Plan

Note: Refer recipients to local district Medicaid office staff if more detailed Medicaid service information is needed.

A-140 MEDICAID ESTATE RECOVERY PROGRAM

A-140.1 Legal Authority

Authority for operating the Medicaid Estate Recovery (MER) Program is published in Section 1917 of the Social Security Act and Nevada Revised Statute 422.293.

A-140.2 MEDICAL ASSISTANCE OVERVIEW Program Overview

Division of Welfare and Supportive Services
Medical Assistance Manual
15 Jul 01 MTL 01/15

A-140.2 Program Overview

Federal and state law mandates state operation of a MER program whereby correctly paid Medicaid benefits are recoverable from the estate of a deceased Medicaid recipient. Recovery is accomplished only after the death of a recipient and at a time when there is no surviving spouse, children under the age of 21 or adult disabled children.

Regulations of the MER program affect individuals who received Medicaid benefits on or after October 1, 1993. Collections will be pursued against the estate of the recipient up to the amount of Medicaid benefits correctly paid or up to the determined value of the recipient's estate, whichever is less.

MER staff is currently housed at DHCFP.

A-140.3 Affected Individuals

MER actions are imposed against Medicaid recipients who are:

- 55 years of age or older when they receive Medicaid assistance; or
- an inpatient in a nursing facility, intermediate care facility for the mentally _____ retarded, or other medical institution, where they are required to pay patient _____ liability for medical care.

A-140.4 Notification to Affected Individuals

Full disclosure of MER program operation is made during the application process. Statements regarding MER are included on the eligibility application and applicants (or their representatives) are given Form 6160-AF, "Medicaid Estate Recovery Notification of Program Operation." Staff **MUST attempt to** secure the acknowledgment (via signature) of information provided on Form 6160-AF. However, the applicant's (or their representative's) failure to sign the form does NOT preclude DWSS's pursuit of correctly paid benefits.

Form 6160-AF, Medicaid Estate Recovery Notification of Program Operation, must be given to all applicants for Medicaid assistance at the time of application for services and redetermination. Be sure the applicant receives the form in English or Spanish, whichever is appropriate.

One copy of the form will be given to the applicant and one copy will be filed in the Medicaid eligibility case file.

Note: Medicare Savings Program (MSP) applicants were excluded from MER effective January 1, 2010.

A-145 REFERRAL OF CASES TO MER UNIT

When a MER-applicable recipient is no longer Medicaid eligible due to death, the case manager MUST forward the case file to DHCFP, Attention: MER, within three (3) working days after the closure of the Medicaid case. If the case is virtual-only (AMPS), notify MER via email at MER@dhcfp.nv.gov. The email must contain the recipient's name, Medicaid billing number, and SSN or UPI.

If the return of a paper case file is necessary, eligibility staff must request in writing the return of the case file. The written request must include the name and SSN of the recipient, the date of the request, the eligibility staff member requesting the file, and the district office where the file should be sent. The request may be faxed or forwarded to DHCFP, Attention: MER utilizing interoffice mail. MER staff will provide the case file within three (3) working days.

Case files for Medicaid applicants who have been denied Medicaid eligibility and who do not have a history of prior approval should not be forwarded to the MER unit at DHCFP.

A-145.1 INITIATION OF MER ACTIVITIES

Upon receipt of the closed Medicaid eligibility casefile, DHCFP MER personnel will establish a MER recovery case. MER staff will validate the recipient's reported resource information.

A-150 FORMS USED FOR MEDICAL PROGRAMS

The following forms may be used when determining Medicaid eligibility:

2468 – Request for Prior Medical Assistance

2511 – Medical/insurance subrogation

5000 – Health Insurance Premium Payment Application